The Fast Track

Winter 2016 Issue

An Emergency Medicine Publication

THE IMPORTANCE OF INTERNATIONAL MEDICAL EXPERIENCES

A THIRD YEAR STUDENT IN THE ED

KEEP AN OPEN MIND

WHAT YOU HAVEN'T BEEN TOLD ABOUT CHOOSING A RESIDENCY

The Fast Track

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ACOEP
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Letter from the Editor

Change happens. Just like the seasons and weather change, life changes as well. The inevitable life changing moments come often, their magnitude of impact ranging from miniscule to life altering. In the last five months I have gotten married, traveled abroad, and adopted a dog. All of these are huge, life-changing events. Two days ago, I forgot my lunch that I was bringing to my shift on the counter at home. Small in perspective, I know, but still a life changing event on that day if you ask me! No matter how big or small, we are constantly being put into places where we have to make decisions, react to new circumstances, and suffer the consequences of change.

While my life has been having some big changes, we here at *The Fast Track* have also been going through some changes. In the past year we have continued our endeavor to print this publication and send it out to the residents and students of the ACOEP world. The resounding response from people nationwide has been positive, and we continue to strive to fill their mailbox or iPad screens with awesome and visually appealing content every quarter.

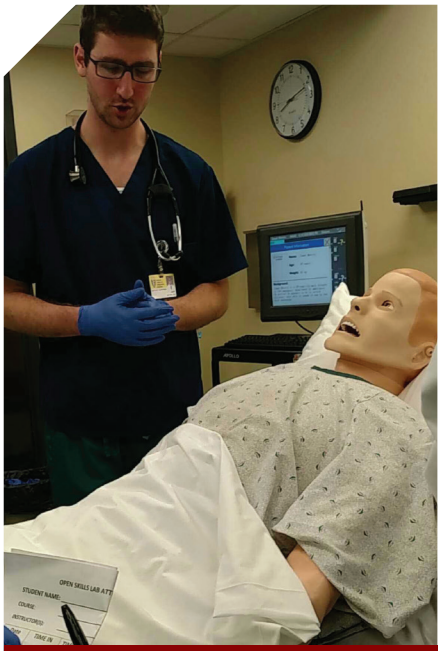
One of the biggest problems we have had in the past has been consistency, primarily with our team. Every year *The Fast Track* team gets shuffled and switched as the officers from the student and resident chapters finish their one year term and new ones are elected behind them. If you can imagine trying to run a full-fledged publication, but every October you have to reset and reteach the majority (or entirety) of the team, it becomes evident fairly quickly that consistency becomes difficult to achieve. Thus far, we have been lucky with outstanding members contributing their time, efforts, and souls into this publication. But luck only lasts so long, so we decided to make *a change*.

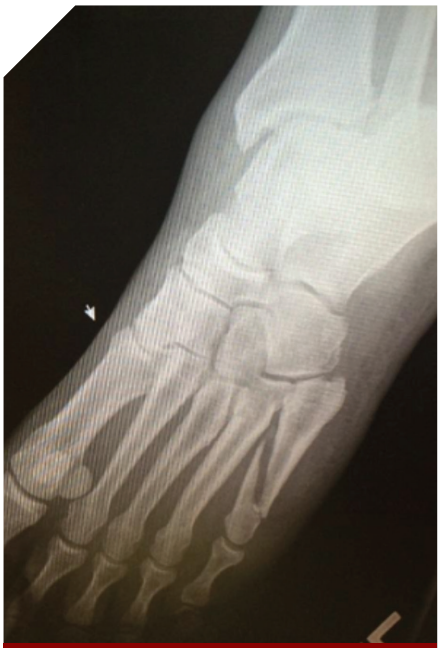
Since last issue our primary design team is now in house with ACOEP, and not in the direct hands of the student and resident chapter officers. So far, we have been undoubtedly impressed with the look and style they have given us, listening to our feedback and ensuring the true colors of *The Fast Track* remain intact. The biggest impact from this change will likely be that the ridiculously time-consuming process of design is no longer on the team's shoulders, and extra time can be spent recruiting and finding bigger, better, and more important content for *The Fast Track*. Keep an eye out over the next year, as there will surely be some amazing articles and awesome things to come!

Cheers,
Tanner Gronowski, DO
Doctors Hospital Emergency Medicine Resident
ACOEP-RC National Secretary

INTERESTED IN CONTRIBUTING?
Let us know: **FastTrack@ACOEP.org**

Contents





PRESIDENTIAL MESSAGE
Resident Chapter

Welcome to the ACOEP-RC! We hope your years are off to a great start and that you've had a chance to enjoy the winter holidays. The ACOEP Resident Chapter Officers and Committee Members have been working hard behind the scenes to evaluate ACOEP's Scientific Assembly and plan for Spring Seminar in Scottsdale, AZ.

We have a great year planned ahead! We are excited to share great procedural and educational opportunities as well as career and leadership insights. The Scottsdale resort is a great venue and we hope you will be able to join us for a top-notch resident focused US lab and hear from the great main college lecturers.

There are also many ways to get involved at the conferences from research and poster presentations, attending lectures and breakout sessions, to participating in committees or running for office. Whatever your interests may be we hope you'll be involved and come see us this year.

Sincerely,

John Downing, DO
ACOEP National Resident Chapter President
ACOEP Board of Directors
Midwestern University
Emergency Medicine

PRESIDENTIAL MESSAGE
Student Chapter

Wow! What an amazing conference in Orlando, FL. There were a record number of attendees at all levels of the organization. The quality of lectures, labs, and social events was excellent. I wanted to personally thank all of the students, residents and attendings that made this such an amazing conference. I hope every single person that came and participated in this event left with new-found friendships, greater knowledge, and fabulous memories.

My name is Timothy Bikman. I am the 2015-2016 ACOEP-SC president. On behalf of the entire newly elected student chapter board of directors, we want to let you know we are 100% dedicated to providing you with the necessary opportunities to network, gain knowledge and develop skills that will guide you to your goal of matching into the residency program that is right for you.

This is a very exciting time for medicine and our profession. The continuous changes in health care and the ACGME/AOA merger for Graduate Medical Education affect all of us. ACOEP is a growing and thriving organization that is proactively adapting to these changes. We cannot be satisfied with the results of the past if we are going to meet the challenges of the future.

We, as a student chapter board, are constantly trying to learn about the challenges you are facing. As we learn about these challenges we will adjust our trajectory accordingly to meet your needs. Please feel free to reach out to any member of the student chapter board with questions, comments or concerns. You can find our names and contact information online at acoep.org/student.

I would like to speak for the 1st, 2nd and 3rd years from across the nation, whose futures have been positively influenced by our 4th year peers. Right now you are in the midst of an emotional rollercoaster as you prepare for match day. We deeply appreciate your example, mentorship and the advice you have given us throughout the years. We wish you the best of luck matching into your program of choice!

To everyone, never forget:

"If you can't fly, then run, if you can't run, then walk, if you can't walk, then crawl, but whatever you do, you have to keep moving forward." –Martin Luther King Jr

Sincerely,
Timothy Bikman, OMS-III
ACOEP National Student Chapter President
WVSOM, Lewisburg, WV

ACOEP Student Chapter
The American College of Osteopathic Emergency Physicians

THE IMPORTANCE OF INTERNATIONAL MEDICAL EXPERIENCES

Shawn Sethi OMS-III
Nova Southeastern University, Ft. Lauderdale, FL

During college I decided to merge my interest in medicine and travel, and had the privilege to visit Chiang Mai, Thailand for a medical trip. I was able to shadow many local physicians at a hospital. This trip provided great exposure to several medical and surgical specialties including medicine, cardiology, neurology, infectious disease, and general and orthopedic surgery among others. Not only was I able to see many different aspects of medicine, but I was also able to experience this in a vastly different setting than the United States. I can definitively say the experience helped to guide my decision to pursue a career in medicine.

So in between my first and second year of medical school, when a chance arose to travel to Jamaica and provide medical care to underserved populations, I knew it would be a great opportunity. I spent two weeks in Jamaica with fellow students and attending physicians from my medical school.

The trip was split into two parts. The first half in the capital city of Kingston and the other half in a rural parish named St. Mary's. During each day of the trip we would choose the medical supplies that were needed for the day and travel to a rural site to set up the make-shift clinic. These sites ranged from churches, schools, small houses to even a prison! The sites did not have pre-existing clinics or medical equipment so we used the available chairs, tables and sheets to set up different sections. These included a triage area in the front of the site, several tables to do histories and physical exams, as well as a private exam area. In addition to medical students, there were dental students performing hygiene exams and tooth extractions, optometry students testing vision and providing reading glasses, physical therapy students assisting with movement disorders and pharmacy students dispensing medications.

Each day a large line of patients came to the sites to seek medical care, some of whom had only received care a year before from the previous medical trip to Jamaica. Once the patients were triaged based on their vital signs and chief complaint, we performed

histories and physicals and presented to the attending physicians. Afterwards we would discuss the assessment and plan and the patient would be sent to either the pharmacy area for medication or other specialties who were at the site. This was an invaluable experience as I was not only able to travel to another country and help the local population, but I also learned how to properly diagnose and treat a large volume of patients.

I am looking forward to setting up an international elective rotation during my fourth year and other future medical trips abroad.

Why is international medical experience important for Emergency Medicine?

1

Efficiency in seeing patients

One of the most important aspects of emergency medicine is providing effective medical care in a short amount of time. This trip was before my third year rotations and therefore was a great opportunity to gain experience in seeing dozens of patients per day and learning how to make quick and accurate dispositions. International medical trips can help with these skills and improve confidence before clinical rotations.

2

Interaction with patients from different cultural backgrounds

Anyone can walk into an ED, and therefore emergency medicine physicians are constantly dealing with a variety of patient populations. Understanding how to interact with patients from a diversity of backgrounds can be helpful in building empathy and breaking down cultural and language barriers. Experiences abroad can provide a way to not only visit another country, but also to learn about how different cultures deal with their health.

3

Improving physical exam skills

According to a study from the Annals of Emergency Medicine, the use of CT scans in the ED increased by 330% from 1996 to 2007.[1] On medical trips without access to laboratory data, EKGs or imaging such as CT scans, there is a heavy reliance on the history and physical to arrive at a diagnosis. These experiences can offer a great opportunity to refine the nuances of the physical exam and learn tips from seasoned attending physicians.

4

Working with other medical professionals

Emergency medicine physicians work as part of a team and consult other specialists to help with diagnoses and treatment. In addition to medical students and physicians, I was able to work alongside dental, pharmacy, optometry and physical therapy students. This helped with learning how to triage patients and determining what additional care they may need. Many medical trips can offer a chance to work with an inter-professional team to provide comprehensive treatment to patients.

5

Diversity of disease

Keeping a broad differential in mind is important especially when dealing with unknown patients. The patients in Jamaica presented with a variety of conditions, some of which are not endemic to the United States. Therefore, international medical experiences can help expose students to unusual disease presentations and rare conditions that may otherwise only be seen in textbooks.

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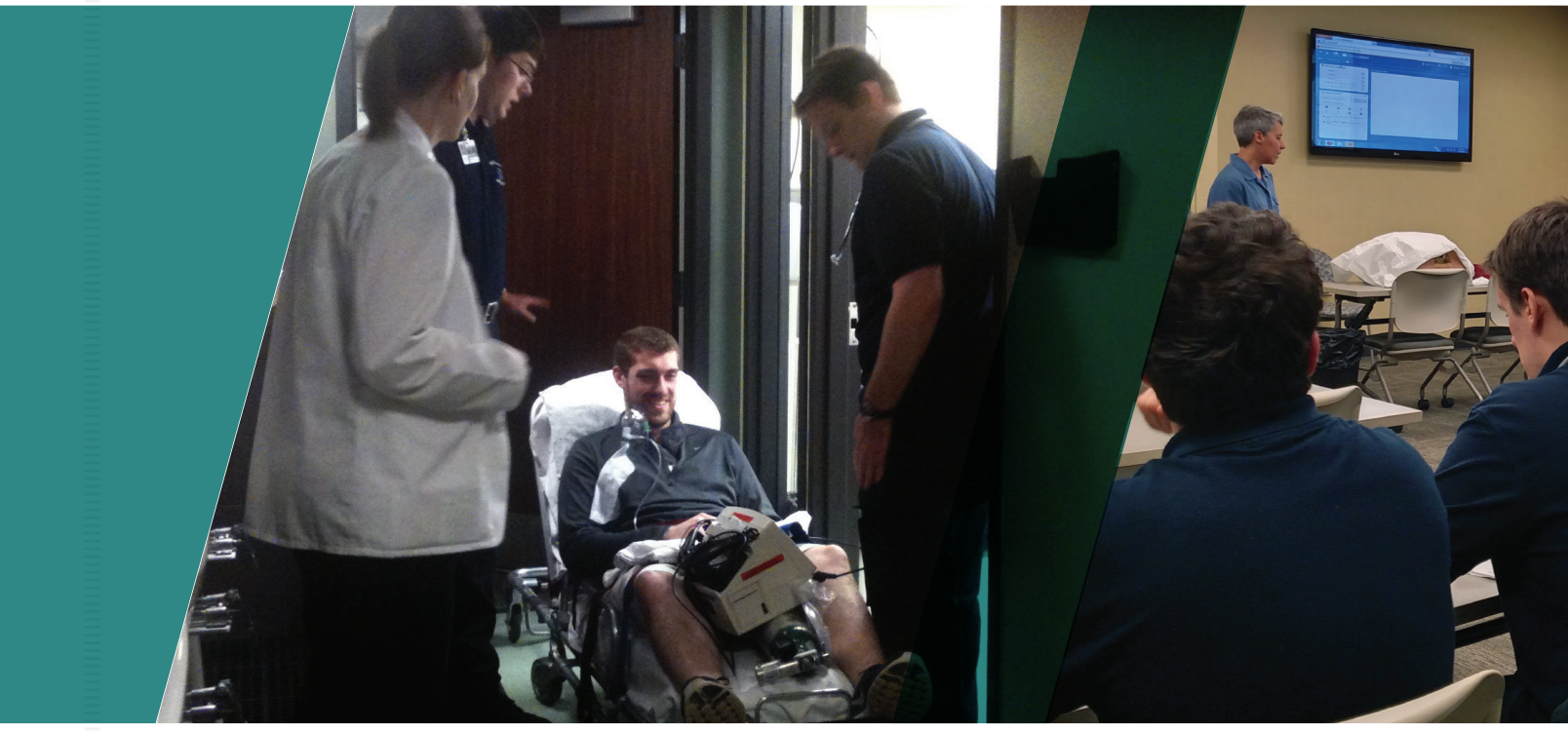
INTERDISCIPLINARY SIMLAB TRAINS PARAMEDICS, NURSES AND EM DOCTORS IN SEAMLESS TEAMWORK

Kent Weaver
OMS-3, OU-HCOM

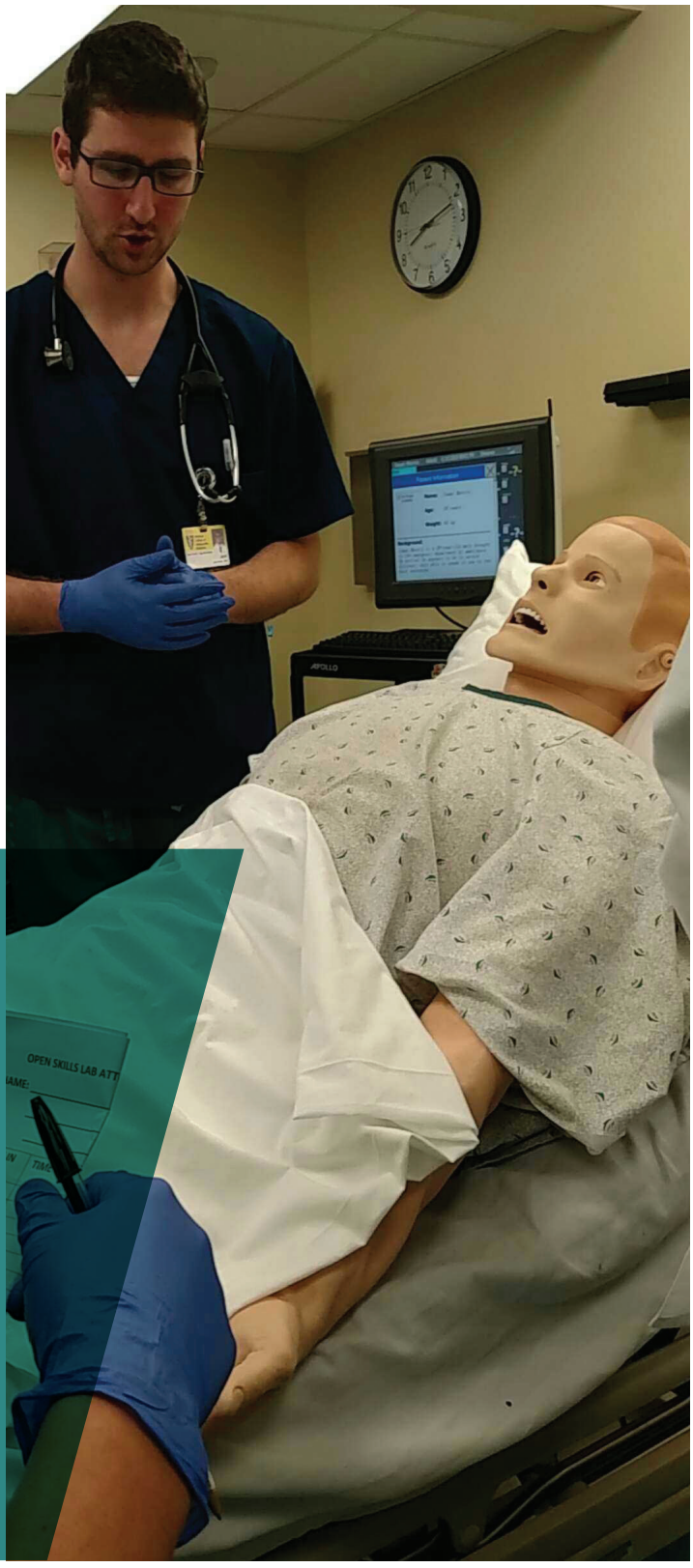
Everybody who has played a team sport has heard all the classic sayings, 'There is no 'I' in team," 'We win and lose as a team," and many more. These are said by every coach, and for good reason, as they are true.



In order to help promote teamwork and prepare for game day, teams practice together. Not many coaches would tell their players to practice individually, and then have them show up on game day and introduce them to each other. This would obviously lead to confusion, as the players would not know what to expect from the other members of the team. The unfortunate truth is that when it comes to the emergency room, efficiency and communication are critical, yet the metaphorical 'players' all practice individually. The physicians, nurses, and paramedics practice separately leading up to the game, and then expect things to work smoothly on game day. As there are many nurses and physicians who have years of experience working together, this dilemma is more focused at new nurses and medical students.

Many residents and medical students practice mock codes and slowly take more and more responsibility in real codes as their knowledge and confidence grow. They do their best during these mock codes to simulate the real situation with expensive mannequins that turn blue, can be intubated, display simulated monitors, and there are even crash carts organized like those in the emergency department. The one major detail that is left out is the nursing staff, which is such a vital component of running an efficient emergency department. A good team of nurses who are on the same page as the physicians can make the department run smoother and lower the stress of everyone involved. On the contrary, nurses and medical students that have less experience and are unfamiliar with the preparation for certain procedures, can delay procedures and medications, and increase the stress of everyone involved. The question has to be asked: Could some of the miscommunication and delays be avoided by spending some time practicing interdisciplinary communication outside the stressful environment of the emergency department?

At Ohio University Heritage College of Osteopathic Medicine, the Emergency Medicine Club put together an event to promote interdisciplinary learning, and better the communication by different members



of the healthcare team. Medical students, nursing students and paramedic students were involved in a simulation was meant to mimic a real scenario from the initial on-scene involvement to the stabilization of the patient in the emergency room.

Paramedic students arrived on the scene and practiced taking a brief history and vitals. They then called these in to the nursing student who had the opportunity to practice taking a report. The nursing student then gave the report to the medical student and the team practiced preparing for the incoming patient. Upon arrival to the room, the paramedic students practiced giving an updated report. The role of patient, who had up to this point been a human, was transferred to the 3G mannequin and the simulation was carried out on the mannequin. Each member of the medical team had a chance to practice their respective roles in the scenario. After the scenario concluded, all students watched a recording of the scenario and instructors from each respective field discussed improvements that could be made in communication and efficiency. In order to practice some of the suggested improvements, the same team of students ran the scenario again.

These types of experiences are limited in the first few years of medical school, but they are very helpful for those involved. As medical students, we focus on learning the medicine and physiology, but in the fast-paced emergency room setting, failure of communication between the different members of the healthcare team can make all the medical knowledge in the world somewhat worthless. It seems that something this important deserves a chance to practiced and perfected outside of the pressures of the emergency room.

Congratulations to the new Board Members for the Student Chapter and Resident Chapter! These qualified, capable individuals are spearheading efforts from publication of *The Fast Track*, to planning and executing conferences, to representing their Chapters to ACOEP's Executive Board.

Congratulations!

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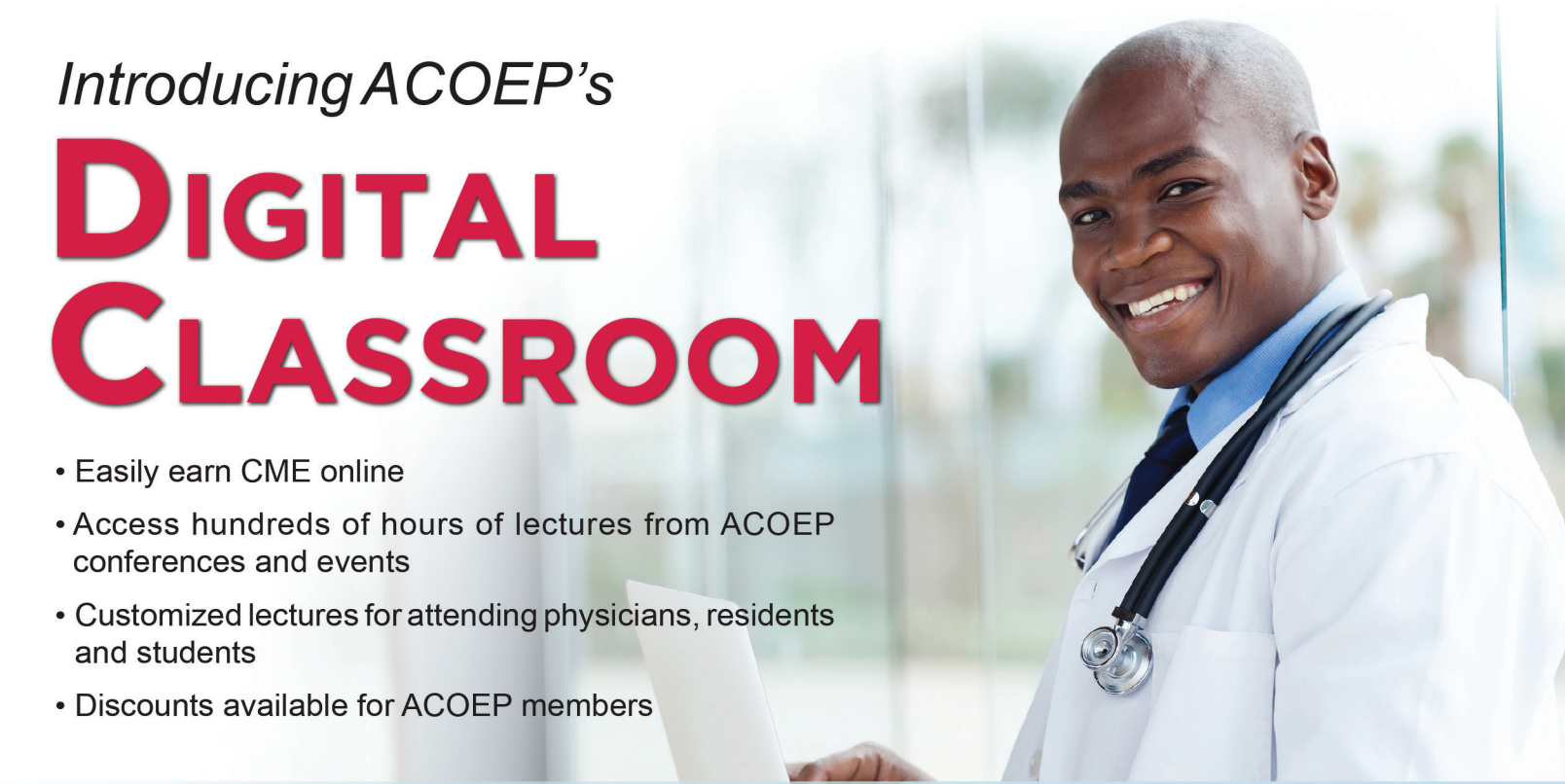

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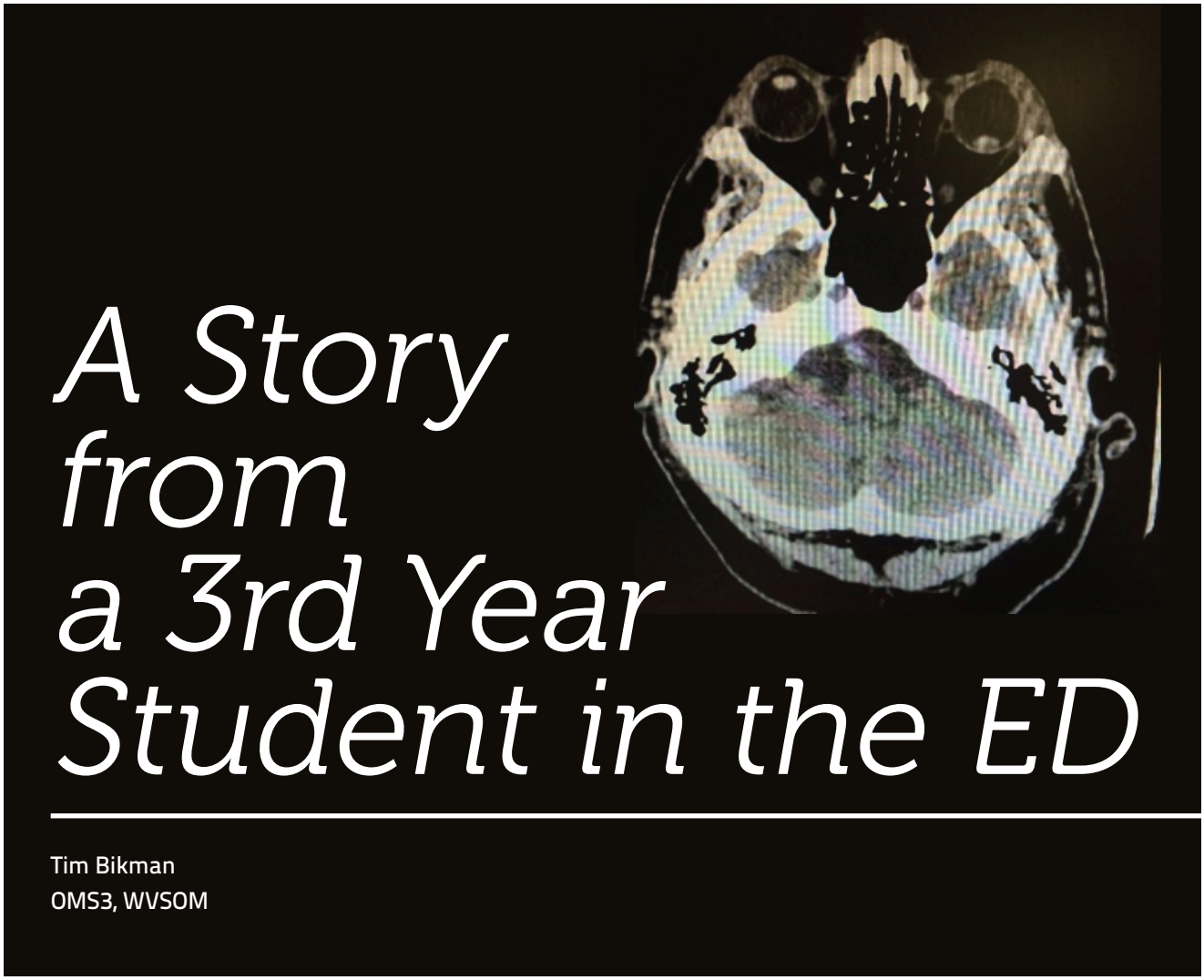


A Story from a 3rd Year Student in the ED

Tim Bikman
OMS3, WVSOM

I was working the night shift in the ER one night as part of my 3rd year rotations. At around midnight a patient came complaining of being assaulted. My attending asks me to go and see what is going on.

As any excited young 3rd year would do, I think to myself, "Okay this is a trauma patient, don't screw this up. You should probably make sure he is stable first." So I check his chart and noticed all vital signs are normal. I quickly go into the patient's room and notice he is sitting comfortably in bed and shows no signs of distress. Now I jump into my onslaught of questions.

I first ask, "What brings you into the ED tonight?"

"I was arguing with my girlfriend and before I knew it, her and her son were beating me up then threw me down a flight of stairs," he replied.

These questions continued until I got a basic idea of what is going on. In summary: The 38 year old Caucasian male patient was assaulted by his girlfriend and her son which ended with him being thrown down a flight of stairs. The patient was repeatedly hit in the face, head, back, and abdomen. The patient complained of difficulty seeing out of his left eye, had a lot of pain in his left arm and left foot. All other review of systems questions were negative. All of these complaints occurred during or immediately after the altercation. Patient denied loss of consciousness. Patient denied any recent drug or alcohol use. Patient denied any medical illnesses or surgeries. Immunizations are up to date, no allergies, takes no medications, and stated that he is a generally healthy person.

When examining the head I note multiple small abrasions over and around the orbital area bilaterally, a small hematoma forming under the left eye and a sluggish left pupil. During my musculoskeletal examination I noted multiple small/superficial lacerations on the left anterior forearm, left thigh and left lateral foot. During the neurologic exam the patient was noted to have decreased vision in the left eye. All other physical exam findings were unremarkable. After leaving the room I took a moment to gather my thoughts and assess the situation. First of all, what are the important things that we need to address? Why can't he see out of that left eye? Does he have a Cranial Nerve II lesion, corneal abrasion, lens issue, amaurosis fugax, or even a stroke? Second, what is likely causing the pain in his left arm and foot? Is it a simple sprain/strain, just bruising, or is there possibly a fracture to one of the extremities? The next question is what do we do about it? Do we CT scan the whole body, do we need to do a FAST exam of the abdomen to check for internal bleeding, and what about labs?

I WILL BE MINDFUL ALWAYS OF MY GREAT RESPONSIBILITY TO PRESERVE THE HEALTH AND THE LIFE OF MY PATIENTS, TO RETAIN THEIR CONFIDENCE AND RESPECT BOTH AS A PHYSICIAN AND A FRIEND...

These were all the questions swimming through my mind as I prepared to present the case to my attending. I didn't really know all the right answers but my attending patiently guided me through a great approach to further managing this patient. After seeing the patient together we decided to order a Complete Blood Count (CBC), urine drug screen, a CT of the head without contrast, Chest X-ray (CXR), x-ray of the left forearm, and an x-ray of the left foot.

Finally, the labs and reports came back. CBC showed no abnormalities. Urine drug screen was negative. Left forearm x-ray was negative. Radiologist report of the CT scan of the head was completely negative. I went back into the patient's room and informed him of the good news. Then went on to explain that he will likely be sore for a few days, but medically he was doing well.

The patient very quietly and humbly asked, 'Do you have any idea why I can't see well out of my eye?" pointing to his left eye.

I really didn't know what to say. I decided to tell him the truth, 'I am really not sure. Is it alright if I discuss this with the doctor and get back to you?" He agreed and I rushed to find my attending.

While discussing the situation with my attending he suggested we look at the CT scan ourselves just in case. I looked at it first while he was dealing with other patients and as I scrolled through the images I noticed something odd when looking at the globe of the eye (see previous page). The left eye looked like it was turned around backwards. I found my attending and showed him what I had discovered. He knew right away the eye was not on backwards but that something was obviously wrong. We called the radiologist and asked him to review the images again. The radiologist and ER physician determined the patient likely had a dislocated lens.

I ran back to the patient's room and told him the diagnosis and then explained that we would need to transfer him to a larger facility that has an ophthalmologist on call that can repair the damage to his eye.

He agreed then quickly asked me about the results of the left foot. He said, 'This left foot is really starting to bother me. Are you sure there is nothing wrong with it?"

I suddenly realized we had failed to order the left foot x-ray. See the image to the right to see what we found when imaging the left foot:

Notice the large fracture to the mid-shaft of the 5th metatarsal. So we decided to add orthopedics to the lists of

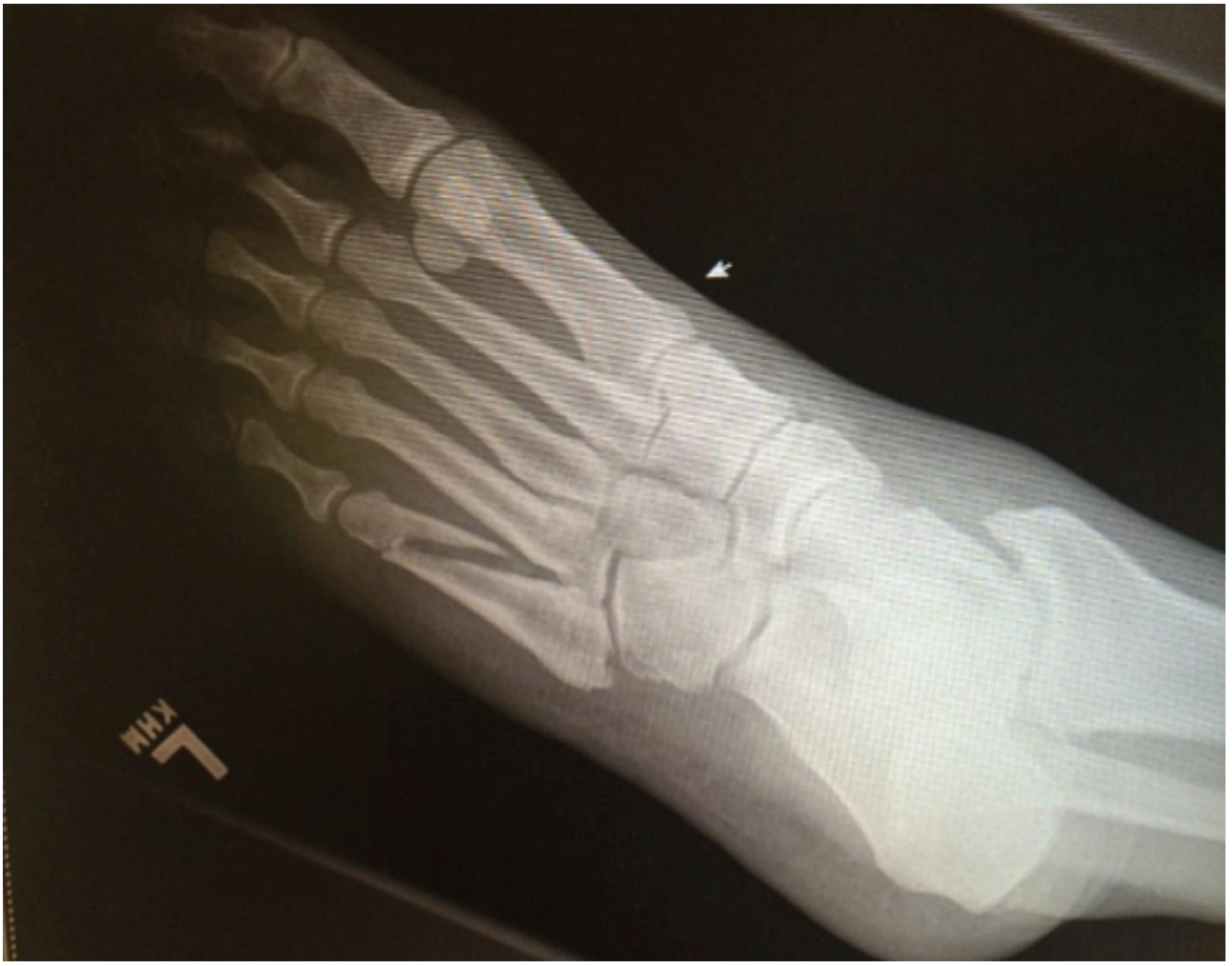
consults for our patient.

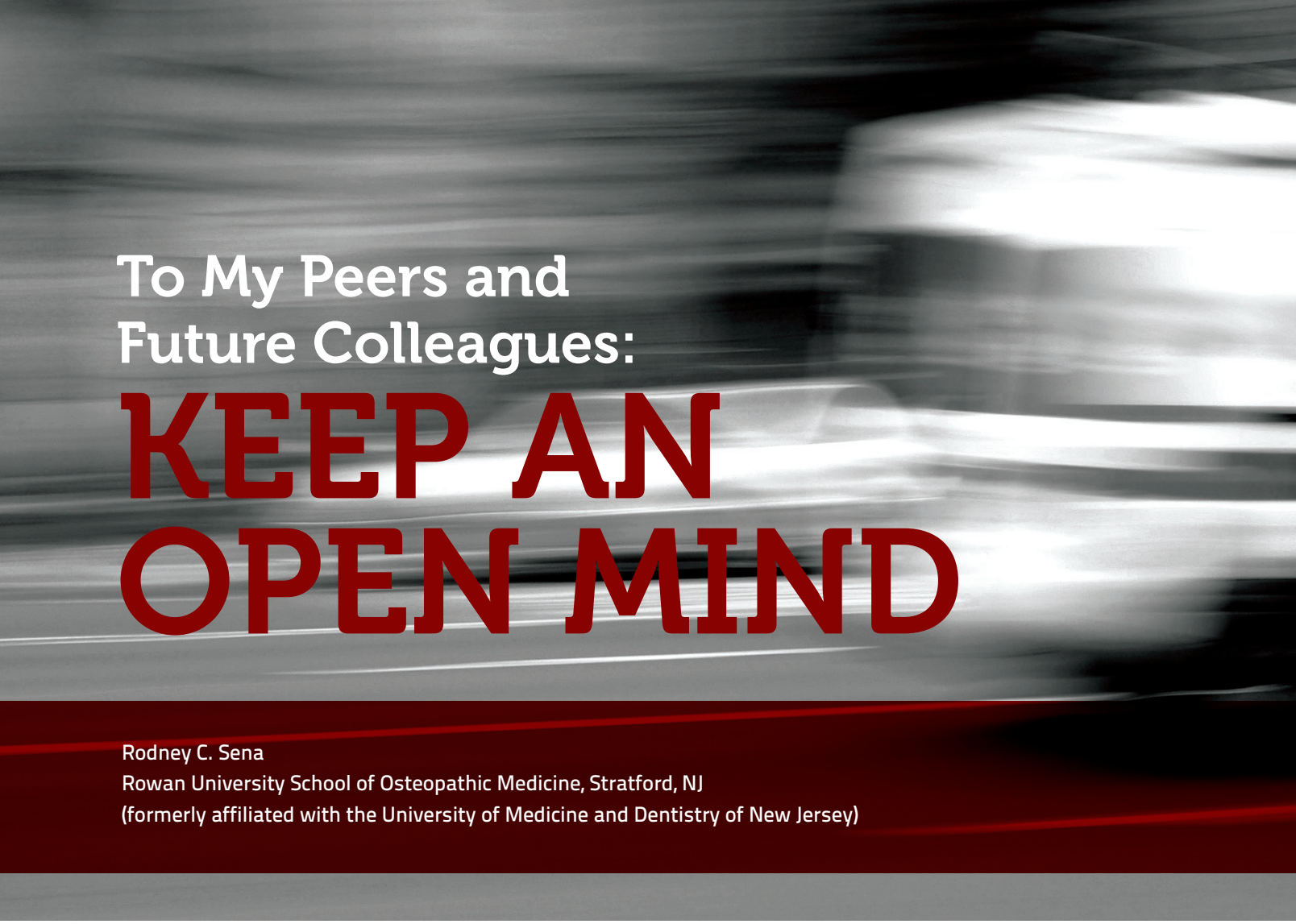
After discussing these latest results with him he said he had one last question. At this point I was getting awful nervous of any of his questions as I worried about what else I may have missed. He simply asked, "How am I supposed to get home from the hospital you are transferring me to? That is over three hours from here and the only person I know from this state who will help can't afford to drive there to pick me up."

I was really stunned by the question. It seemed so simple and clear to me that we needed to send this patient to a larger facility to deal with his recent medical issues. The thought never crossed my mind how this would affect the other aspects of his life.

As I drove home that night I tried to reevaluate that case to learn from my mistakes to be a better student doctor tomorrow. What if I would have listened a little more closely to his complaints and taken special note to make sure those issues where clearly and promptly addressed?

As a future osteopathic physician I will take an oath that says, in part, "I will be mindful always of my great responsibility to preserve the health and the life of my patients, to retain their confidence and respect both as a physician and a friend…" I am honored and humbled by the opportunity, and great responsibility, to study and practice medicine. In the future, I hope to better listen to my patients and consider the effects the treatment plans we develop together will have on all parts of their mind, body and spirit.





To My Peers and Future Colleagues: KEEP AN OPEN MIND

Rodney C. Sena
Rowan University School of Osteopathic Medicine, Stratford, NJ
(formerly affiliated with the University of Medicine and Dentistry of New Jersey)

As with many of my first year peers, my white coat is still whiter than paper, and my study habits are constantly adapting to cope with the volume of knowledge that is medical school. Prior to matriculation, I often dreamed with friends about the hospital we would create and operate together – each person leading their own department. Some were set in stone in their specialty, others (myself included) had an idea but were considering others, and the remaining simply had no clue. We barely scratched the surface of the medical world; the sky was our limit when it came to our careers. So how did I respond when asked the age-old question of "what kind of doctor do you want to be?" I simply smiled and stated, "A good one." To that, a friend and mentor, now a first-year emergency medicine resident, responded, "Good. Keep an open mind."

My relationship with this mentor began five years ago while volunteering with our home town's ambulance squad. He remains not just my senior by four years but also my role model. During that experience, I jumped at every opportunity to learn, and he took the opportunity to teach. With each patient encounter, he challenged me to look past the obvious and to use my knowledge to begin putting pieces of the medical puzzle together. He taught me to be curious and keep a sense of skepticism and reality. However, on the day he received my response to that age-old question, he taught me nothing with his response of open-mindedness. Instead, he reminded me of something I already knew.

In New Jersey, each of the 21 counties operate vocational-technical high schools that provide students with a career-focused curriculum to supplement traditional coursework.[1] I attended my county's health sciences high school, not out of interest in healthcare but out of the desire to be challenged academically. I began secondary education with those indirect benefits at the forefront of my thoughts. This decision was my first major decision that taught me to keep an open mind.

During my undergraduate career, I continued to volunteer as an emergency medical technician (EMT). Prior to my third year, I began working in an emergency department (ED) as a technician. These two experiences combined helped fuel my desire to pursue emergency medicine as my top choice specialty. In these two settings, I met many like-minded individuals looking to gain exposure to healthcare with similar aspirations for a future in the field: future physicians, nurses,

"SLOW DOWN – THERE'S SO MUCH MORE," I OFTEN TELL MYSELF.

therapists, and a variety of other careers. Now in medical school, classmates tell stories of experiences similar to mine, heading full force towards EM. As excited as I am to shadow in the ED, attend intubation workshops, or meet residents and their program directors, I often have to stop and remind myself of the bigger picture that is medicine. There is such a spectrum of fields that I cannot definitively say at this point that I will go into EM. "Slow down – there's so much more," I often tell myself.

Nonetheless I have to thank the field of EM. It has provided me and many others with experiences that will shape our healthcare careers. EM and related fields are conducive to learning – they are available 24 hours per day, 7 days per week, 52 weeks weeks per year. Many pre-professional students utilize EMT experience as a part of their school applications, hoping it will help them stand out.[2] Others gain experience in EDs as medical scribes or as volunteer research assistants, both of which are beneficial to the department at low or no costs.[3,4] It is during these experiences that students become enamored with the "sexy" field that is EM, with life-or-death situations like traumatic injuries and cardiac arrest. On the other hand, students in the ED can also see the primary care complaints, the uninsured, the homeless, the criminals, and the drug addicts. These are two very different sides of medicine that can change a student's perspective.

EM has provided many with a first-hand view into medicine. Students set aims for a career in the field and often forget that the world of medicine is much, much larger than the walls of the ED. There are practitioners in outpatient offices for primary and specialty care. There are hospitalists that care for patients once they are admitted. There are surgeons and anesthesiologists working cases in the operating room. There are intensivists caring for the critically ill in the intensive care units. Even within EM, there is such a variety subspecialties: critical care, prehospital medicine, palliative care, toxicology, pain medicine, pediatric EM, sports medicine, and undersea/hyperbaric medicine – and these are just the ones that allow board certification by the American Board of Emergency Medicine.[5]

So, just as I was reminded, a reminder to my peers and future colleagues: there's nothing wrong with aiming towards EM, just remember to keep an open mind.

What You Haven't Been Told About Choosing a Residency

Andy Little, DO

This article will NOT include facts or figures. It will NOT include references to studies or science in how to best make your "residency choice." The main reason for that is because at the end of the day where you choose to do residency (and by choose I mean where you rank programs) has little to do with objective data or other information. How do I know this? Because, like most type-A, anal retentive medical students I had a spreadsheet. I remember putting it together in October of my 4th year of medical school. I thought I was so smart. I included things like location, education conferences, attendings, off site rotations, etc. Each with a one to five rating system, that I filled out after rotating and interviewing at each program. I performed this religiously, and after completing the form I compiled my rank list. When I saw the results I was astonished. Why? Because the two programs I had the best experience at were ranked 3rd and 4th. I went over my rubric again and again, and figured out the flaw: I was not making this decision in a vacuum, but my rubric was.

So after thinking about it more, I decided I would throw my rubric out in regards to how I would rank my top three choices, and then after that apply the rubric. What commenced next, I believe is what lead to me making the right choice for my family, for myself, and a happy life in residency. I boiled it down to four questions:

1. Where do you want to go?

I believe this is the MOST undervalued and least asked question in regards to residency training. I asked myself where I wanted to be in five, 10 and 20 years. So when thinking of your future imagine the following: Where do you want to practice? Urban Hospital vs Community Hospital? Downtown vs. Small Town? Do you want to be in academics, or do a fellowship? Answering these questions will help you decide what kind of program you're looking for.

2. Where is your light house?

I pose it in this way, to focus on the premise that light houses are located strategically to help you find your harbor, and if there is one thing I have come to appreciate is that we all need someplace to retreat to. Whether you use this as a specific location (close to parents, siblings, etc.) or that you have realized that you need to be in a place with specific facilities or activities to be happy. Realizing this as a student and when choosing a program will aid your work/life balance in residency immensely.

3. Does the program make you happy when you're there?

Happiness trumps most things, and is a huge key to residency. Simply ask yourself the question 'Am I happy here?" If you're looking for confirmation on whether or not you could be happy there, look to see if the current residents are happy. If they are, you will probably be as well.

4. Are you inspired when you're there?

So this is the hardest question to answer and in my experience was something I found only at a few programs I looked at. This, along with happiness, will be an essential factor in not only having a good experience while in residency, but also in having a long successful career in EM. This inspiration will come from patients, attendings, nurses, techs and others you come in contact with in your program. This is something I consider myself lucky to have found—every day I go to work in my ED I have an inspiring experience where it reenergizes me to come back the next day.

So when it comes time for you to make your choice, where you want to spend three to four years of your life as an EM resident, please consider the above. Rubrics and metrics work, but they lack personal touch and can be too generalized. I wish each of you the best of luck in this process, and hope you each find that perfect program just for you.

Introducing ACOEP's Council for Women in Emergency Medicine

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The inaugural meeting of the ACOEP Council for Women in Emergency Medicine took place on October 20, 2015 at the Scientific Assembly held in Orlando, FL. This event welcomed over 90 registrants and drew a diverse mix of students, residents, and attending physicians. The conversations ranged from feeling guilty for taking maternity leave, to finding time during a twelve hour shift to pump breast milk, to the gender wage gap, and finally to questions of balance between the do-it-all mom and hard-working physician.

Emergency Medicine draws a certain type of woman - someone who is strong, decisive, adaptable, and willing to think outside the box in terms of solutions. However, even the strongest women are not immune to the issues above and the council seeks to give them a voice. The leader of the council is Chris Giesa, DO who promises to take the concerns of the council to the highest levels of ACOEP leadership and spark debate and perhaps resolution. Dr. Giesa is not only the leader of this newly formed council, but she is also President-elect of ACOEP and as such has committed to improving the field not just for women, but for everyone.

Another role that the council seeks to fill is mentoring young physicians and current students. Female physicians bring a unique perspective to the profession and with this comes the exceptional ability to lend support and guidance to fellow women who may be in need. Engaging with others who may have felt the same apprehensions and gone through the same hardships can be a great source of inspiration and consolation. Through this group, connections will be made and relationships nurtured that can enlighten and motivate the next generation to be strong and exemplary osteopathic emergency physicians.

This new council is in the early stages of development so its future and overall impact is still to be determined, but one thing is clear: women in emergency medicine have a new outlet for their voices to be heard to catalyze change for the better. "*Inspiring. Mentoring. Leading. Shaping the Future of Women in Emergency Medicine.*" This is the mission statement of the council, and the future looks bright for this new council! Be on the lookout for future meetings at ACOEP's 2016 Spring Seminar in Scottsdale, AZ and at the 2016 Scientific Assembly in San Francisco, CA, and come join this wonderful group of women.

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